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Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2008

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Organization : Johns Hopkins Home Care Group

Category : Home Health Facility

Issue Areas/Comments
Provisions of the Prosposed Rule

Provisions of the Prosposed Rule

See Attachment

CMS-1545-P-14-Attach-1.DOC

Reply to CMS Regarding the Proposed Rule Changes for Home Care

Since the inception of OASIS, the burden on home care agencies has increased. The face of home care has dramatically changed. Market changes, staffing trends and reimbursement have all been affected by implementation of OASIS. It was the hope that with the latest changes some of the burden would be eased for home care agencies. This has not happened. In reality the opposite has occurred.

The nursing shortage has affected all segments of health care delivery. Our agency has experienced, on average, a 40% vacancy rate since OASIS implementation. Retention and recruitment of staff is at an all-time low. Clinicians just aren't willing to come to home care with all of the documentation and regulation requirements that sum up to additional time per patient, for non-clinically related tasks. Many homecare experienced clinicians are leaving the field to practice in other settings as they feel it is an impossible job. This also puts a burden on the staff that the agency is trying to retain. We are spending thousands of dollars to train staff in OASIS documentation and PPS. Recruiting new staff is a challenge as they are not willing to commit to the time that it takes to be trained. The amount of supervisory time to "co-case manage" these patients has increased, yet again, burdening the agencies with the responsibility, but not giving them the dollars needed to do so.

The OASIS assessment, if correctly completed, takes a new clinician, months to begin to understand. The questions are not intuitive and many are difficult to understand. Clinicians are burdened with the tedious task of remembering the detail behind each MO question to provide the appropriate answer. Our agency alone had to customize the software utilized with our point of care documentation system, in order to have the Chapter 8 explanations imbedded into the assessment, so the clinicians would have a constant reference. This costs money both in time for creation and implementation of these enhancements. We have a commitment to excellence and correctness with our patient care and documentation, yet struggle with the burden that the OASIS assessment has meant for our staff.

Our agency has instituted "Start of Care" nurses who just go out to open patients to home care and complete the OASIS assessment, as it is too difficult to be an expert in all aspects of the clinician's roles and responsibilities. Gone are the days when a clinician would perform their own start of care and keep the patient to manage the case. We are in survival mode. If the clinician does not answer the OASIS questions correctly, the loss of revenue could be monumental.

OASIS has forced us to add another layer of hand-off of care. But where is the continuity of care for the patient? This is a "dis-satisfier" to some staff, as they would prefer to open their own patient cases but struggle to understand the OASIS assessment to the degree that is needed to be successful in documentation.

Additional burden has also been felt due to the oversight that is necessary to train and monitor the correctness of the clinician's documentation. This translates into new positions for the home care agency for training and monitoring, which means more dollars spent. A new clinician can expect to have multiple revisions to their documentation to just meet the standards of the OASIS assessment.

It appears the proposed rule is putting measures in place to help control some areas that may be abused by some agencies. "Coding creep", has been sighted as a concern. For the agencies that have endured the increasing expenses necessary to have dedicated coders and documentation specialists on staff to code and document correctly, the new proposal seems to penalize us.

It is unclear why CMS would find it necessary to introduce a decrease in reimbursement over the next three years. Health care costs are soaring, staffing is more and more difficult and expensive, the cost of living is increasing and the cost of doing business is increasing, therefore it is especially hard to understand why CMS would propose a decrease in payment for home care agencies. Agency expenses are increasing yet our payment will be decreasing.

Home care is the place where patients prefer to have their health care needs met. It certainly is more cost effective than a hospital yet at the same time home care agencies are being told to tighten their belts even more in the face of soaring health care costs. CMS needs to consider relief for the home care agencies not cuts.

We are very concerned that the proposed increase of 2.9% could potentially be frozen as has happened in the past and this increase is for one year while the proposed cut of the standardization rate of 2.75% is for 3 years.

We agree with the proposed LUPA payment to eliminate the SCIC.

We would encourage CMS to consider specific variables such as co-morbidity in rate determination.

We agree with the outlier provision but do not understand why it needs to be capped at 5%.

The new HHRG structure, while more complex does not yield a material change in reimbursement for our organization. I agree with the theories suggested by the methodology.